PROGRESS

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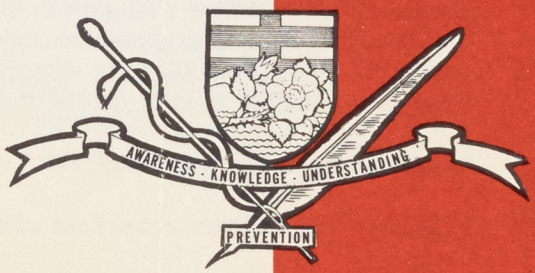
IN THIS ISSUE



THE ALCOHOLISM FOUNDATION OF ALBERTA

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AND EDMONTON CLINIC
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The Alcoholism Foundation of Alberta is a private Foundation incorporated in 1951 under the Societies Act, financed by provincial and municipal grants, corporate and private contributions. The Foundation's three point program of Education, Treatment, and Research, is directed at the eventual Prevention of Alcoholism in Alberta. Patient counselling, medical, educational, and research services are provided through the two centres in Edmonton and Calgary. The Foundation recognizes alcoholism as a treatable illness, a serious public health problem, and therefore a public responsibility.

TREATMENT

Treatment services are available to anyone desiring help with a drinking problem. The treatment program includes individual counselling, medical treatment, and group therapy. A service fee of $10.00 is charged to the patient. No patient is ever denied treatment due to inability to pay.

There are no consulting fees.

Edmonton and Calgary out-patient clinic hours — 9 a.m. to 5 p.m.
Monday through Friday.

The Alcoholism Foundation of Alberta

Executive Director - MR. J. GEORGE STRACHAN

PROGRESS

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Editor: T. G. Coffey

PROGRESS is published every two months as part of the Foundation's Educational program in order that a more comprehensive knowledge, greater understanding, and more objective viewpoint of the illness alcoholism be provided the people of this province. All material in PROGRESS is believed to have been obtained from reliable sources, but no representation is made as to the accuracy thereof. Opinions expressed in the articles themselves are not necessarily those of The Alcoholism Foundation of Alberta, but are those of the authors reported.

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Comment

In this issue two members of the Foundation's Research Department write of two uses of research. **R. W. Jones**, Associate Director, Research, gives us *Some Thoughts on Prevention.* Most of the prevention that is carried out by alcoholism programs is secondary prevention; i.e. finding and treating the alcoholic after he has become alcoholic. Primary prevention is directed at the elimination of the causes of alcoholism. One of the ways to do this is to apply research to determine the socio-cultural factors related to alcohol use and abuse. This is the type of research the Foundation is planning and conducting.

Amongst other studies the following are, or will soon be, underway: 'Drinking Patterns in Alberta,' 'Who Knows What About the Foundation,' 'Response to Advertising,' 'Distribution of Deaths from Cirrhosis of the Liver,' and others that were fully reported by Mr. Jones in **Progress** Volume II, Number 4.

W. E. Wilby, Research Associate, writes of another important role of research, and gives an example of a study that was conducted, within the Foundation, to provide a Foundation department with statistical information for its own use.

A. De Boe, Secretary of the National Committee Against Alcoholism in Brussels, Belgium, at the end of 1959, at the invitation of the Polish Committee Against Alcoholism, made a study of the alcohol problem in Poland. He has kindly given us permission to publish this shortened translation of his valuable paper. M. de Boe writes in his paper that "with closer and more frequent contacts with the ideas of programs in other Countries . . . the Polish program will gain in depth and effectiveness." Although the problems in Poland and North America are not similar, there are many points of comparison and some useful information we can learn from their successes and failures. **Progress** hopes to publish in future issues more studies of the problem and its control in other countries.

Medicine Looks at Alcoholics Anonymous is one of a series of releases prepared by General Service Offices of Alcoholics Anonymous in New York. This is the fifth in this series that we are publishing.

Cathrin M. Peltenburg is a Psychiatric Social Worker with the Adult Guidance Center, Department of Public Health, San

Francisco. *Casework with the Alcoholic Patient* is a condensed version of a paper she gave at the 82nd Annual Forum of the National Conference of Social Work.

In September the Foundation was host to the North American Association of Alcoholism Programs at their eleventh annual conference in Banff. This was a most successful meeting and **Progress** will publish some of the outstanding papers in future issues.

Dr. Jellinek's New Book

The Disease Concept of Alcoholism by **Dr. E. M. Jellinek** has just been published by the Hillhouse Press, New Haven, Connecticut.

In his new book Dr. Jellinek, who is Consultant to the Foundation, explores the idea of alcoholism as an illness. He reviews the historical development of attitudes towards alcoholism as a disease, analyzes the varied scientific approaches to the problem, and describes the beliefs of different segments of the public around the world His original classification of the alcoholisms lays a foundation for a disease concept based on scientific principles.

The Disease Concept of Alcoholism is an essential book for all who are seriously interested in this public health problem.

The book is being distributed by the Publications Division, Yale Center of Alcohol Studies, 2162 Yale Station, New Haven, Connecticut. —T.G.C.

N.A.A.A.P. CONFERENCE

The North American Association of Alcoholism Programs held its eleventh annual conference in Banff, September 25th to 30th, 1960. The Alcoholism Foundation of Alberta was the host agency to the meeting this year, with Mr. J. George Strachan, Executive Director, as Program Chairman.

The N.A.A.A.P. is composed of forty-four government supported alcoholism programs in the United States and Canada.

The theme of this year's conference was centered about administration and the problems of training and developing personnel for agencies. 120 persons participated in the conference, including administrators of government alcoholism programs, members of their Board, and staff, from 27 States and 5 Provinces.

The Hon. Norman A. Willmore, Alberta's Minister of Lands and Forests, brought greetings from the province at a reception and spoke

on the progress being made today by government agencies in recognizing the serious cost of alcoholism to the economy, health and welfare of the people.

The Hon. Dr. J. Donovan Ross, Alberta's Minister of Health, was guest speaker at the banquet. He stressed the need for the integration of government support with that of the professions and interested persons in the community.

Successful meetings and workshops were held on many of the problems of administering alcoholism programs and were addressed by notable specialists in the fields of administration, treatment, education and research.

The program was highlighted by presentations from other organizations in the field of alcoholism. Bill W., co-founder of Alcoholics Anonymous, reviewed the growth of that fellowship and its relations with government supported programs. He paid tribute to the many outside friends of A.A., and noted that, at the recent A.A. Conference, the delegates moved to offer every cooperation to public agencies.

R. Brinkley Smithers, President of the National Council on Alcoholism, emphasized the importance of joint activities and close relationships between government and voluntary agencies.

Marvin A. Block, M.D., chairman of the Committee on Alcoholism of the Council on Mental Health of the American Medical Association, outlined the responsibilities of the medical profession to the work of alcoholism programs.

A number of Foundation staff members attended and participated in the Conference. R. W. Jones, Associate Director, Research, presented a paper on the *Implications of Recent Sociological Research*, Dr. David M. Bell, Medical Director, was a member of a panel on treatment, and Dr. E. M. Jellinek, Consultant to the Foundation, presented an evaluation of the proceedings at the closing session.

The N.A.A.A.P. officers elected for the next two years are:

Dr. John R. Philp, Berkeley, California, president;

J. George Strachan, Edmonton, Alberta, first vice-president;

Norbert L. Kelly, Raleigh, North Carolina, second vice-president;

George C. Dimas, Portland, Oregon, secretary-treasurer;

H. David Archibald, Toronto, Ontario, past president.

Some Thoughts on Prevention

By R. W. Jones

PREVENTION as used by public and private organizations such as the National Council on Alcoholism and the Government supported alcoholism programs, is primarily secondary in nature. Heavy emphasis is placed upon education with little effort directed toward primary prevention — the elimination of the causes of the illness.

There is good reason for this approach to prevention. It stems from the lack of information which we have about the factors which can control the problem.

It seems clear from a number of studies and comments that there are a variety of facilitating and precipitating factors in alcoholism and in the other problems associated with drinking. While the evidence on any particular factor which has been suggested as being related to problem drinking is not conclusive, most studies have produced evidence which suggest that the causes can be classified as physiological, psychological or socio-cultural in nature.

Our present knowledge indicated that, for the most part, the physiological effects of alcohol and alcoholism are fairly stable given a sufficiently large population.

While we have considerable lack of information in the area of psychological effects in the use of alcohol, there are a number of studies being carried on in the United States and Canada which should produce, within the next two or three years, sufficient information to provide reasonable preventive techniques.

The sociological factors involved in alcoholism and alcohol use

are currently practically unknown. Since we lack information in this area we are greatly retarded in efforts towards prevention.

Concepts in Prevention

What we need to recognize is that prevention may occur via a variety of techniques. If we take an analogy to malaria perhaps this will help us to put prevention into perspective.

Malaria can be eliminated in a variety of ways:

1. Malaria can be treated with a drug which reduces or eliminates the symptoms of the disease.
2. The anopheles mosquito may be eliminated by spraying D.D.T. or some such similar insecticide on the habitats of the mosquito.
3. The population in malarial areas can be removed and hence malaria eliminated as a disease of that population.
4. Without any recognition of what the casual relationships between malaria and the anopheles mosquito are, swamps can be drained and hence the disease eliminated.
5. One can introduce into a population a particular set of blood cells which are immune to malaria and the person having these cells does not contract malaria.

IF THIS IS A fair analogy, then prevention in alcoholism may be attacked from a wide variety of positions and it may be accomplished without ever learning the etiology of the disease. Consequently, in planning any preventive program, we should avoid eliminating factors which do not seem particularly promising unless we have some rather strong evidence that factors will not or cannot be of any effect.

In other words our present approach of a large number of shotgun efforts in public education should not be shunted aside until such time as we are prepared to evaluate the actual effectiveness of these public activities. Further, the immediate effort should be towards evaluation, in some way, of what our presentations do. There are, at present, only crude measures for evaluating such activities. One method is to provide at each public activity some gimmick which will require the public involved to give some kind of response which can be evaluated.

This might be, for example, a short questionnaire which would test the knowledge of the subject which people have before the activity and which they have after the activity. Or, it might be a card which persons interested in obtaining further information or receiving publications could send to the sponsoring organization. These, of course, only measure part of the impact of public talks, pamphlets, broadcasts, etc. Another approach is to develop, if possible, more rigorous methods of obtaining referral information from the pa-

tients. It might be possible under some circumstances to tie the referral back to persons who had heard public talks or had read pamphlets.

HOWEVER, perhaps the most fruitful approach to prevention is to find out as quickly as possible what the socio-cultural factors related to alcohol use and abuse are. For example, what are the groups of people who do and who do not use beverage alcohol? What are the social situations in which alcohol is consumed? Is its use limited to ceremonial occasions or to meals? When and where may alcohol be used? What are the social functions of beverage alcohol? Do these differ among high school, college, and adult populations? What kind of sanctions are imposed on people who do not consume in the prescribed way? To what extent is consumption a matter of individual choice and to what extent is the individual subject to social pressures to consume? How is consumption distributed among different populations—urban *vs* rural, male *vs* female, by age groups, by economic groups, by ethnic groups? How is alcoholism distributed in these same populations? These are only a small number of the many questions about socio-cultural factors to which we need answers.

In addition to studies of socio-cultural factors, we must evaluate the effect of particular kinds of treatment techniques when these are used in places other than urban metropolitan centres. We need to know, insofar as possible, what the most effective methods of treatment are in a wide variety of situations.

What then is required is an integration of the various functions of alcoholism programs, but only after each has been assessed in terms of its contribution to a preventive program.

Summary

Almost no primary prevention exists in the field of alcoholism today. What is practised is secondary prevention—early case finding through public education and treatment of the sick person. Primary prevention involves the identification of pre-disposing factors and of the populations most susceptible to the disease. At present, prevention consists of efforts to educate the public to the consequences of alcoholism. These efforts appear to be fruitful. Actually there is almost no evidence to indicate how effective these programs have been.

RESEARCH as an aid to ADMINISTRATION

By W. E. Wilby

AT THE ELEVENTH Annual Meeting of the North American Association of Alcoholism Programs the delegates received a paper, *Implications for Administrators of Recent Soliological Research,* by R. W. Jones, Associate Director, Research, The Alcoholism Foundation of Alberta.

In essence, Mr. Jones made a plea for recognition of research as an equal partner in program planning and operation. He cautioned scientists to evaluate and interpret research findings in terms meaningful to administrators; and he outlined methods by which administrators could obtain the services of competent specialists as a positive aid to effective, economical functioning.

The question might arise—and in fact did—as to just how research proves itself of immediate practical value to those charged with operational responsibility. The delegate did not ask for examples of how research **might** be of assistance; he simply requested an illustration of research accomplishment which had promoted "effective, economical functioning."

Is such a question impertinent? Are the contributions of research so self-evident as to deny the dignity of a reply? Certainly not! The question is extremely pertinent, and the contributions of research are anything but self-evident.

IT IS PROBABLE that every alcoholism program, regardless of size or goal, has adopted some procedure by which accomplishment is assessed. How valid or reliable these tools may be is open to question; in fact some of the 'reasons' advanced for the very existence of 'program assessment' statistics make one wonder whether we are dealing with rationale or rationalization! The crucial point, however, is that governments, board members, donors and the public at large expect administrators to justify their operation mechanically.

As an example of research contribution to the administration of The Alcoholism Foundation of Alberta, we may cite the continuing scrutiny paid to the 'patient progress trend' assessment.

FROM the inception of the Alberta program in 1953, a record was kept of every 'case,' and an attempt was made to evaluate response to treatment. One of the first tasks assigned to research workers was an analysis of pro-

cedures in this area. It became immediately clear that the term 'case' was without meaningful definition, i.e., total number of cases was in reality total number of files. Many of these files were established without actual service to the alcoholic, and many more files referred to a 'patient' with only transient exposure to 'treatment.' Before any realistic estimate of program efficacy could be made it was necessary to classify files on the basis of nature and duration of contact. Thus evolved a threefold division of files known as Enquiries, Applicants, and Cases.* Where no personal service had been rendered to the alcoholic (Enquiries), or where the contact was brief and service minimal (Applicants), there was little or no justification in assigning progress categories. Where medical treatment, individual and group counselling, and other services had been employed beyond a specified point (Cases) it was felt reasonable that systematic efforts be made to follow-up the patients' later adjustment.

Once it was determined who should be classified according to 'progress,' it became necessary to examine the nomenclature of gradations then in use. Critical evaluation of terms and definition resulted in a rather drastic revision. A system of 'Recovery Indicated' (with three sub classifications defined in terms of fixed criteria) and 'No Recovery Indicated' (with two subdivisions) was adopted.

At this point we could report quite clearly on who was being assessed and by what standard. It was also decided that reclassification would be made at six month intervals from the date of intake.

This system, while imperfect, was generally acknowledged to be a significant advance beyond our original scheme. The Executive Director, Department Supervisors, and staff could now meet questions concerning the program's accomplishment with a fair sense of confidence in a conservative estimate.

SOMEWHAT later in our experience a problem arose concerning the validity of progress trends which included substantial numbers of patients upon whom no recent assessment was possible. The research staff analyzed the problem and found evidence indicating that the trend among patients still in contact correlated highly with that of the last known category of patients who could no longer be located. As a result of this finding, the administrative problem of expending counsellors' time on fruitless attempts to follow-up patients *ad infinitum* was partially solved. At the present time, a patient who cannot be contacted through a period of twelve consecutive month is deleted from the follow-up routine and the last known progress category is accepted as applicable.

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*Definitions and criteria for 'file status' and categories of response to treatment have been outlined in past Annual Reports and the Five Year Review 1953-58 available on request from the Foundation.

The latest administrative problem involves just how long efforts at follow-up and reclassification should persist. With an increasing number of case status patients accruing, the amount of counsellor time devoted to this task is assuming serious proportions. Again research is required to explore methods of maintaining acceptable statistical reliability without detracting from the counsellors' primary responsibility to partients under active treatment. Studies are now being undertaken to test a hypothesis that the degree of rehabilitation attained by patients at a given point—perhaps one or two years—following termination of treatment is an acceptable index of what would be found in open end follow-up.

THE FOREGOING represents a single illustration of the practical contribution that may be made by research staff in the day by day problems of administration. Even this example raises new questions. Is this task properly labelled 'research,' and does it really require the services of personnel trained and experienced in scientific methodology? Perhaps this instance does not fall within the lay stereotype of 'research,' and perhaps many staff members could have undertaken the task with equal facility—but they didn't! The primary responsibilities of administration, treatment, and education either do not permit staff to devote the required time to planning, analysis and revision of statistical procedures, or questions of reliability and validity simply did not occur.

Here we have a case in point of what the Alberta Foundation terms 'internal assessments.' Whether or not there is general agreement as to their status as 'research' is perhaps of little consequence to staff who are ill-equipped or unprepared to undertake this and similar assignments. What is of importance is that 'research' can and does encompass more than abstract ivory tower theorizing. Research can and does provide immediate practical aid in program design and operation.

FURTHER EXAMPLES OF INTERNAL ASSESSMENTS

(a) "Non Government Contributions to Foundation Programming."
Administrative use: revision of procedure for soliciting public financial support.

(b) "Monthly and Annual Fluctuations in Rates of Patient Intake and Case Status Attainment."
Administrative use: focused attention upon possible factors affecting patient persistence in treatment.

(c) "Group Counselling Attendance and Effect Upon Patient Recovery."
Administrative use: decisions on continuance and procedure in group methods.

(d) "Patient Accounts."
Administrative use: revision of service fee, medical and welfare assistance policy.

ALCOHOL PROBLEMS IN POLAND

By A. De Boe

IN 1959 I was invited by the Polish National Committee on Alcoholism to make a study of the alcohol problem in Poland. The three topics I studied were:

—Alcohol Consumption in Poland

—The Problem of the "Inveterate Drinker" and the Alcohol Addict

—The Campaign Against Alcoholism in Poland

CONSUMPTION

The Country of Vodka

Up to and during the eighteenth century the Pole's main drink was beer. I was told the story of a Pope, who had spent several years in

Poland where he developed a taste for Polish beer. Many years later when he was Pope, he lay on his death bed and murmured "Piwo di Polonia" ("Brew of Poland"), for he really believed in the curative value of Polish beer. His attendant Cardinals, not knowing the drink, mis-translated his demand as "'St. Piwa of Poland, pray for us." That's the story anyway!

But today little beer or wine is drunk; Poland is now the country of vodka. In 1955 the per capita consumption of distilled spirits was 5.82 litres (1.3 imperial gallons) of a reported 50% alcohol. [In Canada the per capita consumption of distilled spirits, of 40% alcohol, was .75 gallons]

Distillation has been done in Poland since the Sixteenth Century. The nobles had the sole right to distill vodka, which became an important source of revenue for them. The feudal peasant who did not drink vodka was not popular with the nobles, so that he felt obliged to drink it. In the Nineteenth Century the workers, who were descendants of the peasants, inherited their taste for vodka. With the development of industry in Silesia, Lodz, Warsaw, Godansk and other centres, vodka became the inseparable companion of the Polish worker; an agreeable but treacherous escape from the hard realities of life.

Drinking vodka is a cult in Poland; the man who does not, is no man, is not a true Pole! This is a serious condemnation in Poland where to be a man *and* a Pole are the two noblest titles a person can have. Vodka, heritage of a feudal system, now plagues hundreds of thousands of Polish families.

The Control of Consumption

The large consumption of vodka created more and more complex problems in the rapidly growing industrial centres. Several attempts were made by the government to control its abuse, the most recent being in 1955 when local authorities were given the power to prohibit the sale of beverages, containing more than 18% of alcohol, on *Saturdays and holidays*. But this law is easily evaded, and anyone who really wants a drink can get one anywhere at any time. No Polish government has dared to pass any stricter laws about drinking.

THE "INVETERATE DRINKER" AND THE ALCOHOL ADDICT

Many visitors to Poland are surprised at the quantity of bars and cafés in Warsaw with their quiet, well-behaved and sociable customers. Clustered round small tables, the elegant, courteous, well-educated Poles drink, by choice, coffee, tea, or mineral water. Café life is most popular, especially in the cities where living accommodation is often uncomfortable, so that a large number of people spend many hours of comfort in restaurants and bars. Cinemas are

crowded from ten o'clock in the morning, and it is almost impossible to get seats for the theatre.

But Poland is a country of contrasts. A few yards from a fashionable café, the visitor finds a different world of noisy, intoxicated vodka drinkers, men and women. Sleeping and unconscious bodies are stretched out on the sidewalk. Others crowd round the visitor, shake his hand and overwhelm him with their friendliness; soon a round of drinks is bought, and then many more, for partying and drinking together are daily social phenomena.

A. The Basic Cause of the Excessive and Pathological Drinking

A complete report of the causes of the Poles' heavy drinking would be too long for this paper. But we would like to point out a few facts:

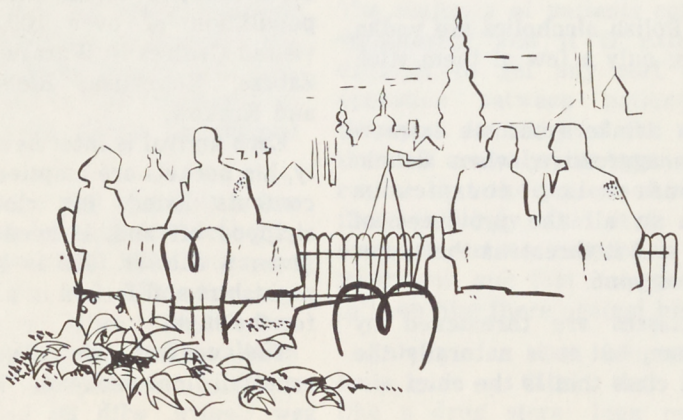
1. The Poles for the past 150 years have lived in anxiety and insecurity. For a hundred years prior to 1914, Poland was a conquered and occupied colony of either Prussia, Austria, or Russia.

2. Until quite recently Poland had a feudal system. The nobles, who were the great landowners, kept the poverty struck peasant in subjection.

3. No other European people suffered as the Poles did in the last two world wars—not to mention the Polish war of 1920. They still remember the terrors, privations and suffering they went through.

4. Poland experienced a major social and economic depression in the years between 1918 and 1939. Unemployment was widespread and millions emigrated.

5. In 1945 and 1946 two thirds of the population were homeless,



wandering vagrants. Venereal disease, child mortality and tuberculosis were rampant in a country without a formal structure and without any adequate medical organization. Yet the Poles worked feverishly. Industrialization and reconstruction were planned and developed with miraculous speed. Millions of agricultural workers emigrated to the new industrial centres, where they worked and lived in intolerable conditions for months, without giving up.

6. The Stalinist period between 1949 and 1956 was a nightmare and everyone (even the Socialists and Communists) worry about the future and wonder if Gomulka will complete the ambitious plan he started in 1956.

This whole generation has been scarred by anxiety and privation, and now many seek oblivion in vodka.

B. Characteristics of Polish Alcoholism

—Most Polish alcoholics are vodka drinkers; only a few of them stick to beer.

—Polish drinkers become extraordinarily aggressive when drunk. Drunkenness is a conspicuous problem in all the provinces of Poland, and it threatens the security of everyone.

—All classes are threatened by alcoholism, but it is naturally the working class that is the chief victim.

—Many young people drink in a frightening manner, with but one end—to get drunk.

—Women drink far less than the men, but there are hundred of thousands of them and their children who are ill-treated by their drunken husbands.

C. Treatment Facilities

In Poland there are two distinct types of facilities for the inveterate drinker and the alcoholic: Sobering-Up Centres and Alcoholism Clinics. We must distinguish between them.

Sobering-Up Centres

In an act passed by the Polish government in April 1956 any drunk person whose behavior is a threat to public order can be arrested by the police and taken to a Sobering-Up Centre and kept there until he is sober.

In thirteen large cities these Centres are being opened and will be, eventually, in all cities with a population of over 100,000. We visited Centres in Warsaw, Poznan, Zabrze, Kotowitza, Bielsko-Biala and Krakow.

Each arrival is interviewed briefly, his pockets are emptied and the contents listed, his clothes are stripped off and, if needed, he is given a shower. He is handed a nightshirt and locked in a bedroom for the night.

The centres are always full, especially on weekends. The Warsaw Centre, with 80 beds, dealt

with over 20,000 people in 1958. On occasions the local military barracks have to be used to house the overflow from the Centre.

But sobering-up by itself is no solution to the problem and all too often when the enforced stay is over, the drinker returns to the bar.

The Centres play two most important roles. They are an excellent source for discovering alcoholics, whose addresses are given to the local Alcoholism Clinics; and those who are detained in the Centres do get the impression that they are considered and treated as if they had an illness.

Alcoholism Clinics

The law of April 1956, referred to above, states that drinkers who have symptoms of chronic alcoholism, and who by their behavior demoralize minors or threaten the security of their family, will present themselves for treatment in an Alcoholism Clinic or general hospital.

Prior to the new law, only a few consultation bureaux for alcoholics existed. Now about 300 Clinics are in operation, and 150 more are being planned. More than 600 doctors, psychologists, and qualified nurses are employed in these Clinics.

We spent several days in three of the twelve Warsaw Clinics, and had the opportunity to talk with the staff and with some of the inmates.

IN most western clinics we try to create an atmosphere of peace and quiet, but in Poland the clinic staff work feverishly. There is such a great shortage of space that frequently we discovered the doctor examining the patient in the same room the psychologist is interviewing his. Dr. Kulisiewisz, a very well known Warsaw psychiatrist, told me one evening that that day he had treated 67 alcoholics, six of whom were new patients.

But it is less the excessive number of interviews than their enforced character which makes them therapeutically unsuccessful. The majority of patients come involuntarily, and it is extremely difficult to get any sort of cooperation between patient and therapist. In many of the Clinics the staff are only just beginning to realize that the patient should be there willingly, that it is in his own interest to cooperate in his treatment, and that it is pointless to keep him there against his will.

Antabuse is used frequently. I have seen a Clinic that looked like a drug store; long rows of

patients, who entered, received their pill from the psychologist, drank, saluted, turned and disappeared until the next day.

The Clinics have great difficulty in making the alcoholic realize that sobriety is the most important part of his recovery. There is not the time nor the staff to treat the basic conflicts of the patient and the enforced treatment only too often imposes a barrier between the patient and therapist. The net result being that many patients again start to drink after three to six months of treatment.

ONLY in Poznan can the patient attend group therapy sessions. It was once tried in Warsaw, but without success, and nowhere else has it been attempted. I was often told that the reason for this is that Poles hate enforced meetings, that they talk too much and find listening difficult.

If you wish to study group therapy methods or the treatment team approach do not go to Poland. What is worth observing, however, in this young industrial country, is the courage with which they are facing their alcohol problems. They realize only too well that there is still much to do, they are critical, and eagerly listen to a foreigner's point of view. They would like to do so much more, but there are too many alcoholics for the limited staff and facilities. As elsewhere in Europe, the results of compulsory treatment are not encouraging.

THE CAMPAIGN AGAINST ALCOHOLISM

The National Committee Against Alcoholism

In 1948 the National Committee was organized. It is composed of representatives of the Trade Unions, the Ministries of Health and Justice, and from Women's and Youth Organizations. Its Board is made up of doctors, lawyers, teachers, and priests.

The Committee does not campaign against vodka itself, but rather tries to warn and protect people, particularly the working classes, against the excessive use of alcohol. Since its inception, largely through the cooperation of newspapers and radio, it has succeeded in creating a favorable atmosphere for a rational examination of the problems of alcohol.

The Committee was largely responsible for the Law of April 1956. Armed with this law the Committee is able to continue the campaign against alcoholism in all the provinces. It is responsible for seeing that the law is carried out, that Sobering-Up Centres and Clinics are opened, and that alcohol education is given in schools.

Generally, the work that the Committee is doing is excellent but in some fields it is not so successful. The object of its Educational Program is to try to make the heavy drinker stop and think. But most of its posters and pamphlets do not get close enough to the drinker, to his needs, fears and conflicts; too many are frightening and sensational, so that the alcoholic's typical response is, "I'm not like that. I can take it or leave it."

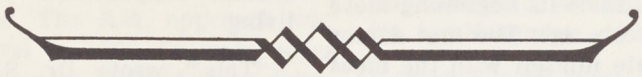
The outstanding achievement of the Committee is the atmosphere it has created through the media of the press and the radio, an atmosphere that is so essential for any chance of success over the problems of alcohol.

CONCLUSION

The Polish people are conscious of the seriousness of their problem. They are not frightened of being critical of their methods and continue to search for more efficient solutions.

The resistance is still considerable in most of Poland. Vodka is still a worshipped object and the alcoholic, an unfortunate scapegoat.

We believe that with the growth of economic development and social stability, a sense of security, cooperation, and peace will spread amongst the Poles—and this will be the most effective safeguard against this obsession with alcohol.



ALCOHOLICS ANONYMOUS

Medicine Looks At Alcoholics Anonymous

IS ALCOHOLISM really an illness? Members of Alcoholics Anonymous, a unique fellowship of more than 300,000 recovered alcoholics, seem to think it is. Perhaps more important, an increasing number of doctors in all branches of the medical profession appear to agree with them. More and more doctors, based on their own testimony at professional meetings and in print, are urging their problem-drinking patients to turn to A.A. and are themselves supporting the use of A.A. therapy in community and industrial health programs.

Medicine has been identified with A.A. since its beginning more than 20 years ago. The first doctor to associate himself with the ideas and techniques that later came to be identified as "the A.A. program" was Dr. William Duncan Silkworth of New York City. The time was 1934 and the place was a private hospital for alcoholics where Dr. Silkworth was the resident specialist.

Five years later in the book, "Alcoholics Anonymous," from which the informal society derived its name, Dr. Silkworth recalled his part in the birth and early growth of the young movement. He cited his experience with Bill W., one of the two co-founders of A.A., described as "a patient, who, though he had been a competent business man of good earning capacity, was an alcoholic of a type I had come to regard as hopeless."

This "hopeless" patient had had an unusual experience while hospitalized for the third time under Dr. Silkworth's care. He had suddenly lost the persistent craving for alcohol which had dominated his life up to that time. And he had acquired the conviction that both he and other alcoholics could be helped if they tried to follow certain simple new patterns of living.

"This," wrote Dr. Silkworth, "has become the basis of a rapidly growing fellowship. . . . This man and over one hundred others appear to have recovered. I personally know of scores of cases who were of the type with whom other methods had failed completely."

Then the man who came to be known by A.A. as "the little doctor who loved drunks," added this prophetic note:

"These facts appear to be of extreme medical importance; because of the extraordinary possibilities

of rapid growth inherent in this group they may mark a new epoch in the annals of alcoholism. These men may well have a remedy for thousands of such situations."

THE CO-FOUNDER of A.A. was a doctor, Dr. Bob S. of Akron, Ohio, an outstanding surgeon whose once-flourishing practice had dwindled to the vanishing point as a consequence of his irresponsible drinking. Bill W. met Dr. Bob in the Spring of 1935 at a time when the former's sobriety seemed threatened. With Dr. Bob's recovery, the two men worked together to help other alcoholics in the Akron area. Their efforts started a chain reaction in the Ohio city and in New York, which has led to the formation of approximately 8,200 local groups in about 80 countries.

Historians have noted that Dr. Silkworth's early testimonial was unsigned. The A.A. approach was still novel in 1939. In many ways it challenged medical experience and theory. To a certain degree, Dr. Silkworth and other doctors who pioneered in working with A.A. risked their professional reputations by endorsing the new fellowship.

The first phychiatrist to study and apply "A.A. therapy" was Dr. Harry M. Tiebout of Greenwich, Connecticut, whose work in the field of alcoholism is known throughout the world. Dr. Tiebout's paper on the "Therapeutic Mechanism of Alcoholics Anonymous," originally prepared for the 1943 meeting of the American Psychiatric Association, was a milestone in growing medical understanding of A.A. For nearly two decades, through his professional practice and public writings, Dr. Tiebout has continued to be one of A.A.'s great friends in the medical field.

Medical recognition and understanding of A.A. was highlighted, in the ten years following publication of the fellowship's textbook, by two significant addresses to formal assemblies of medical societies. Both papers were presented by Bill W., the co-founder. The first was delivered before the section on Neurology and Psychiatry of the Medical Society of the State of New York at its annual meeting in May, 1944. The second was read at the 105th annual meeting of the American Psychiatric Association, at Montreal, Quebec, and reprinted in the American Journal of Psychiatry for November, 1949.

During and since that period many doctors have testified publicly to the impact of the A.A. program on their own approaches to the problem of alcoholism. Following are a few typical comments that have appeared in medical literature as the fellowship and its therapy have become better known.

Dr. Marvin A. Block of Buffalo, N.Y., Chairman of the American Medical Association's Sub-Committee on Alcoholism: "In cooperation with the physician, A.A. forms an indispensable adjunct to the treatment of alcoholics. . . ."

Dr. Karl Menninger of the world-famous Menninger Foundation, Topeka, Kansas: "I have the utmost respect for the work A.A. is doing, for its spirit, for its essential philosophy of mutual helpfulness. I lose no opportunity to express my endorsement publicly and privately where it is of any concern."

Dr. Merrill Moore, Boston, Massachusetts: "From the beginning I have believed strongly in Alcoholics Anonymous and have supported it as an indispensable member of the therapeutic team. The co-operation of Alcoholics Anonymous with physicians is also valuable and commendable."

As A.A. has grown it has become an important ally of many doctors who specialize in industrial and institutional fields.

The magnitude of the problem in the industrial field is suggested in studies indicating that there are between one and two million problem drinkers in American industry, about 30 cases per 1,000 workers.

A number of practical approaches, in which A.A. is a key element, have been developed. Such firms as E.I. duPont deNemours, The Eastmany Kodak Company, General Motors Corporation, Standard Oil of New Jersey, Consolidated Edison of New York, Pennsylvania Railroad, along with many smaller companies, have established programs which recognize that the alcoholic is basically a sick person. These programs are designed to give the worker a new awareness of his problem and to expose him to the experience of A.A. members who have coped successfully with the same problem.

There are A.A. groups in more than 300 medical institutions of all types in the United States, Canada and several countries overseas. These facilities range from small convalescent homes to large Veterans Administration hospitals. They include prison hospitals and facilities designed to help particular types of patients in so-called mental institutions.

In a number of large cities, hospital authorities have set aside special wings or other facilities for the treatment of alcoholics who are sponsored by individual A.A. members.

Alcoholics Anonymous, as a movement, has never established its own hospital facilities or identified the Society with the program or facilities of any institution. In some areas, members have opened rest homes or "farms" catering to other A.A.s, but this has always been done on an individual basis. There is no such thing as an A.A. rest home, hospital, or "farm."

In larger cities the A.A. program frequently has become a vital part of community-wide approaches to the problem of alcoholism. Local committees or commissions in such cases have sought the co-operation of A.A. groups in making

the recovery therapy available to men and women whose drinking has become a community problem.

Medically speaking, A.A. appears to have come a long way since 1939 when Dr. Silkworth ventured the prediction: "These men may well have a remedy for thousands of such situations."

No responsible member of the fellowship would claim, however, that A.A. "has all the answers" to the solution of the problem of alcoholism which has been described as the number four public health problem in the United States.

Most members are content to assert that the program seems to work for them and appears to be successful, immediately or after a period of time, in the cases of about three out of four problem drinkers who turn to it for help. These members are also conscious of the fact that there are an estimated five million problem drinkers in the United States alone, compared with which A.A.'s world membership of perhaps 300,000 men and women is hardly impressive statistically.

There is also recurring evidence that a substantial number of doctors are still not familiar with the A.A. program, either from reading medical literature or from first-hand experience with their own patients.

The concluding paragraph in the pamphlet, "Alcoholics Anonymous and the Medical Profession," distributed by General Service Offices of A.A. seems to sum up the attitude of most A.A. members when these factors are mentioned:

"The picture of progress in helping alcoholics is today an encouraging one," the pamphlet suggests. "At best, however, it is still only a sketch. Humility, therefore, becomes all who labor in this field."

Henry G., Chairman of the General Service Office of Alcoholics Anonymous, died on October 26th in Ireland while on a study trip to the A.A. fellowship in the United Kingdom.

Hank, as he was known, was a valued friend who did so much for the growth of A.A. He visited many groups throughout Canada and spent a week in Alberta in 1955. His advice concerning policy and interpretation of A.A. Traditions will be sorely missed.

Our sympathy is extended to his wife and daughter.

Addiction To Non-Ethyl Alcohols And Other Poisons

Some alcohol addicts, when they cannot get hold of regular drinks (containing ethyl alcohol) will turn in desperation to other intoxicating substances. Depending on availability, they may resort to methyl alcohol, anti-freeze, Sterno, rubbing alcohol, Jamaica ginger, bay rum, vanilla extract, tonic medicines, witch hazel, and the like. When or where legal spirits are hard to come by—as for instance during Prohibition—the use of such substitutes is widespread and the outcome sometimes fatal. The medical literature abounds with cases of blindness or death resulting especially from methyl alcohol poisoning.

The individual who uses non-ethyl alcohol by choice, even when potable spirits are accessible, is a much rarer specimen. Most of the substances under discussion carry on their label, by law, a warning such as "Poison" or "For External Use Only." Thus it must be suspected that those who indulge in spite of the explicit threat are motivated by some complex and largely unconscious self-destructive tendencies. The principal exceptions would be those who have free or easy access to one of the less harmful substitutes, whereas ethyl alcohol comes dear.

The latter type has been described in a report by O. G. Morgan (England). His cases include a nurse, a doctor's wife, a mental patient and a hospital patient, all of whom had access to the hospital supply of methylated spirits, which is ethyl alcohol with the addition of 5 per cent methyl alcohol or wood naphtha. Mixed with cheap red wine to obscure the taste, it produces the same effects as ordinary legal spirits. According to Morgan, such addicts sometimes seek admission to a hospital only to get at the supply more easily. They are extremely secretive about their vice, however, so that accurate case histories are difficult to obtain.

The other type of non-ethyl alcoholic, whose choice of beverage is not governed by economic necessity, has been studied by J. Mendelson, D. Wexler, P. H. Leiderman and P. Solomon (Boston City Hospital and Massachusetts General Hospital). In a recent report they present case histories of nine pa-

tients who had been addicted to toxic alcohols and other poisonous compounds for periods ranging from 10 to 40 years. All had been addicted to ethyl alcohol for as long or even longer periods.

Extensive information was collected from these hospitalized patients, all of whom were adult white males. In addition to medical histories and laboratory tests, their drinking histories and personalities were studied. A number of common characteristics came to light.

All the patients were hospitalized after an episode of heavy drinking which included ethyl alcohol along with other toxic substances, the two most common being methyl and isopropyl alcohols. Five of the nine patients had delirium tremens, two had alcoholic hallucinosis, one was comatose, one severely intoxicated. All had been heavily addicted for many years. Yet within 1 to 4 weeks after treatment began, all nine men could be discharged. They showed only negligible chronic physiological abnormalities, such as a mild polyneuropathy.

In personality traits also the men exhibited some striking similarities. During their hospital stay their behavior was always pleasant, cooperative, apologetic, effusively polite. One volunteered to assist with odd jobs on the ward. Another after a week, offered to leave the hospital so that he would not deprive some other patient of a bed. When asked whether intoxication brought out any aggressive or belligerent feelings, the typical response was, "I never hated anybody. I only hate myself." They described themselves as individuals who neither felt nor expressed hostility.

But hostility against the self was revealed when they were questioned about their reasons for drinking poisonous compounds. "It just deadens you, controls you. You just feel dead." These were the words of a patient who then went on vehemently to deny suicidal impulses. Said another: "It (Sterno) deadens your nerves better." He had also imbibed rubbing alcohol over a period of 17 years and described its effects thus: "It makes you sick as hell, makes your stomach swell up." Nevertheless he continued to drink it.

Not one of these patients had attempted frankly to commit suicide. Although all were aware of the poisonous nature of the substances they were taking, they preferred them to ethyl alcohol because of the stronger effects produced. One patient had gradually developed a preference for paraldehyde over whisky. "I got to like the sensation it gives you. It works faster than alcohol and calms your nerves down quicker." Another, who would drink as much as 4 or 5 large cans of Sterno at a time, said: "It makes you feel light. You think you are on top of the world."

Two findings in this study call for explanation. Why did these

seemingly mild, affable individuals have such a powerful—albeit unrecognized — wish to harm themselves? And why did they not succeed better? Mendelson and his colleagues venture to answer both questions.

That patients as heavily intoxicated as these should recover "so rapidly and so completely" might be due to a number of factors. Over the many years of their addiction, presumably all had developed increasing tolerance to the various substances imbibed. "The known individual variation in tolerance to toxic alcohols is great and may become greater to chronic imbibers." In addition, all were spree drinkers. Between drinking bouts they ate reasonably well and took care of themselves. Their livers and nervous systems were thus spared.

The reason why they turned to toxic alcohols was clearly not economic necessity, or ignorance of the danger, or desire for suicide. The answer appears to lie in the personality of these men, who, "in spite of their ethnic, cultural and developmental differences, had one characteristic in common: a striking degree of submissiveness and compliance. They seemed to be utterly devoid of overt hostility and aggression. Each of them fitted perfectly into Knight's classification of 'essential alcoholics,' with marked dependency and unconscious guilt, self-debasement and need for punishment. We believe that for them ethyl alcohol—which indeed these patients consumed in copious amounts—became too tame; their unconscious needs demanded more severe measures, more complete obliteration, and a nearer tread toward the fearful and tantalizing brink between life and death."

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Casework With The Alcoholic Patient

By Cathrin M. Peltenburg

In thinking about my assignment of today, Casework with the Alcoholic Patient, I pondered how in essence the treatment of this patient is no different than the treatment of any other disturbed person.

If this is so why then is it that case workers, psychiatrists, psychologists so often fail in their attempts to help the problem drinker? Certainly, inferiority-superiority conflicts, extreme dependency needs, demandingness and manuipulation, confusion regarding sexuality, guilt, self-rejection, self-destructive tendencies, and low frustration tolerance are common enough in other nuerotic patients. And the casework done with the alcoholic person is based on exactly the same principles of good listening, respect, acceptance, non-judgmental attitudes, empathy, etc.

How is it then that I, like so many others in the field, upon starting psychotherapy with alcoholic patients, who themselves had asked for psychiatric help, lost them within 4 or 5 interviews.

I began to see that my difficulty in treating alcoholic patients arose not from any qualitative difference between their emotional problems and those of other patients, but from the peculiar intensity and urgency of these problems in alcoholics, which not only necessitated modifications in therapeutic approach, but which also exposed the therapist to certain pitfalls in the area of his own reaction. For instance, the alcoholic patient often feels demoralized and hopeless to such an extent that his demoralization can become conveyed to the therapist who then feels helpless and easily becomes defensive and critical. The extreme degree of dependency and helplessness displayed by the patient, the degree of demandingness and manipulation, of quiet sabotage and expectance of a magic cure without participation, can wear down and exasperate the therapist who is not always sufficiently aware that this patient, overwhelmed with guilt, self-condemnation, expects and "needs" rejection. And since the alcoholic patient is an unsurpassed master at provoking rejection he

only too frequently succeeds in doing so.

There is the person, whose circumstantiality and evasiveness all but wear out the therapist's patience unless he understands that this behaviour is part of his protective armor. This patient's frequent grandiose ideas about himself where he has nothing but failure to show, his submissiveness to the point of servility or, on the contrary, his covert or overt hostility and condescension, put the therapist to a real test. Not to recognize his own frustration and annoyance, and thus not to deal with it, is a severe handicap in treatment.

Then, there is the traditional misinterpretation of alcoholism as a moral weakness. The alcoholic patient himself frequently emphasizes his moral "depravity" and his lack of character and tries to have the therapist agree with him in an attempt to reestablish his familiar role of the bad boy (or girl) at odds with the authorities. A brief remark like "I'm not here to judge, I'm your therapist," shifts the focus from a moral to a therapeutic approach to the problem, it implicitly relieves guilt, and it stimulates the patient to think more constructively.

Another difficulty sometimes shared by patient and therapist alike, is that they may equate sobriety with therapeutic success. This tends to make the therapist over-anxious to keep the patient "dry," with the disastrous result that the patient may turn to drinking as a weapon of retaliation against the therapist whenever negative feelings emerge. The therapist in reaching to the patient's drinking as so many people have reacted to it in the past makes it difficult for the patient to react differently to it himself. The relationship of the bad boy (or girl) to a disapproving society is perpetuated. This does not mean, however, that one should not take a position regarding whether or not a patient drinks. The therapist unequivocally supports the view that there is no cure for alcoholism, in other words, that the patient cannot become a social drinker, that he will have to give up drinking entirely if he wants to arrest the process of progressive alcoholism.

What is meant is that the therapist sometimes gets unduly anxious regarding the patient's drinking. This is at variance with our usual therapeutic attitudes. We would hardly expect a person who has never been able to keep a job to lose this symptom the moment he entered therapy, yet we sometimes seem to feel that an alcoholic should not drink any more after starting treatment.

In addition to presenting emotional problems to the therapist, psychotherapy with alcoholics calls for certain modifications in technique. The alcoholic's guilt, discouragement and anticipation of

failure and rejection necessitates a more active approach than the usual passive, receptive attitudes; a mere "interested listening" is not enough. The therapist must work to establish quick rapport and a feeling of trust on the patient's part if he is to keep him as a patient There are several ways in which this can be achieved.

With the common prejudice of the alcoholic, that no one but an alcoholic can understand his problem, it will be necessary to give some indication somewhere that one understands that the patient's drinking is often beyond his control, that one knows what agonies, mental, moral and physical, he is going through, how strong his need to drink must be to outweigh the consequences of arrests, debts, loss of wife, home, and self-esteem. It is further extremely important to be alert, or as I call it, "to hunt" for signs of achievement—a good work record for instance, the fact that he has merited respect from a boss "who always takes him back" —and to comment on these facts with recognition. This is an exceedingly valuable means in establishing rapport and has the additional value of rekindling extinct self-esteem which is the first step toward recovery in that it brings hope to an utterly discouraged person.

Actually, building self-confidence and self-tolerance is, I think, the most important aspect of treatment. To do this, a positive relationship between patient and therapist is essential. Since the alcoholic patient cannot well tolerate his aggressiveness and anger, the emotional support of the therapist is necessary while the patient experiences these unpleasant emotions. When such support is given and maintained, despite the patient's unconscious machinations to be rejected, it enhances his confidence in himself and enables him gradually to tolerate more of his own emotions.

Another difficulty that must often be overcome at the beginning of treatment is the alcoholic's tendency to isolate his drinking from his psychic life, to regard it as a mysterious foreign body entirely beyond his control. He is the patient who describes his drinking habits and then sits back with a "and now you cure me" attitude. The unperturbed therapist may combat this attitude through interested questioning about the onset of drinking and the patient's relationships with others at that time, through conveying to the patient that he actually does drink to produce some effect, for example to be more at ease with a girl friend or to ameliorate his feelings of depression. This tends to set him thinking and to start his participating in the therapeutic process.

In view of what has been said earlier it is obvious that it is necessary to make concessions to the patient's demanding attitudes in early treatment. Whenever de-

mands cannot be granted, "giving" in another area should be attempted to prevent the patient from feeling rejected, and the anger of disappointment with which he reacts to necessary frustrations should be dealt with so that these emotions will not disrupt the therapeutic relationship.

With those patients who minimize their problem, who only want medical treatment—"just a couple of shots will do it"—I find that outright disagreement: "I don't think they will—no shots on earth will do it for you," startles them into awareness that, maybe, they will have to do their part. I frequently add that with 15 or 20 years of drinking they have quite a battle ahead of them—but that it can be done, and this largely depends on how convinced they are of the seriousness of their problem.

With the unsophisticated patient I do not speak about individual therapy, but simply offer them a return appointment and if this is accepted and well used, I ask if they would like to continue coming on a regular basis. This gives the person, who has no understanding of what casework or therapy means, a chance to find out what "talking treatment" can do for him.

With the psychiatrically sophisticated patient who specifically requests psychotherapy, the intake interview and further treatment can be conducted more nearly as it would with a non-alcoholic neurotic patient. Such a patient is better equipped and prepared to tolerate a passive approach on the therapist's part than are most alcoholics.

It will be evident from this paper that a deliberately planned active approach on the part of the therapist at the onset of therapy is necessary in most cases and that it often means the difference between keeping a patient in treatment and losing him. It is further interesting to consider that differences in approach diminish or even disappear, not only where greater motivation on the patient's part exists, but also where treatment has continued for some time and the patient has developed greater tolerance for frustration, lost some of his fear of facing himself, and gained greater confidence.

Nothing has been said about the perfectionist attitude which we so frequently find in our patients, nor about the psychopathic personality whom, in some cases, I did find treatable. Neither have I mentioned the importance of working with the non-alcoholic spouse which so often results in striking improvement in the patient, even where the patient himself does not receive treatment. Many other aspects could have been highlighted.

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